



**State of Connecticut
Department of Social Services
Medicaid School Based
Child Health Program**

General Program Information

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State of Connecticut Medicaid School Based Child Health Program

Background:

The Federal Individuals with Disabilities Education Act (IDEA) ensures that all children with disabilities between the ages of 3 and 21 have available to them a free appropriate public education (FAPE) that emphasizes special education and related services designed to meet their unique needs and prepare them for further education. Under Part B of IDEA, school districts must prepare an individualized education plan (IEP) which specifies all special education and related services to be provided to a child with a disability. Medicaid, a joint state-federal program, offers school districts reimbursement for many of the covered medical services included in an IEP and provided to Medicaid eligible children.

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program provides medical assistance to certain low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid (CMS) administer the program. Each state administers its Medicaid program in accordance with a CMS-approved State Plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements.

In Connecticut, Medicaid is operated by the Department of Social Services, the single State agency administering the Connecticut Medical Assistance Program. The School Based Child Health Medicaid program (SBCH) is the mechanism by which the Local Educational Agency (LEA) may seek Medicaid reimbursement for Medicaid-related health-care services when provided to an eligible student pursuant to the student's Individualized Education Program (IEP). The SBCH also provides a means for LEAs to seek federal reimbursement for expenditures related to administrative activities that are included in the SBCH provider agreement that are related to the state's Medicaid program.

For additional information pertaining to Statutory Regulations, the Connecticut Medical Assistance Program, Connecticut General Statutes, IDEA and other program information, please consult the SBCH webpage at <http://www.ct.gov/dss/cwp/view.asp?a=2349&q=526930>.

Enrollment in the SBCH Program

The first step in participating in the SBCH program is to enroll with the State's contractor, Hewlett Packard (HP). To enroll as a provider, districts will need to obtain a National Provider Identifier (NPI) Number. This can be done through the website <https://nppes.cms.hhs.gov/NPPES>. Once the district has secured their NPI number, they may access the online enrollment application through the website www.ctdssmap.com, select Provider, then Enrollment. Follow the step-by-step instructions on the web page to submit the district's application request. In addition, a formal request to the Division of Health Services, CON/Rate Setting Unit at DSS should be submitted on district letterhead by the district seeking enrollment in the program. Request should be addressed as follows:

State of Connecticut DSS
SBCH Program - CON/Rate Setting
55 Farmington Avenue, 9th Floor
Hartford, CT 06105-3725

What's Next?

Once a district has obtained approval through HP and is considered a provider under the program, preparation begins for participating in the quarterly Random Moment Time Study (RMTS). Participation in the RMTS is mandatory for all districts enrolled in the program. In order to separate the costs of providing Medicaid covered services from all other costs and expenses incurred by school districts, a CMS acceptable allocation base has to be applied to the Medicaid reimbursable costs incurred by school districts enrolled in the SBCH program. The RMTS is the CMS approved time study allocation method. The RMTS process identifies the portion of time that staff for each participating school district spends performing Medicaid reimbursable tasks under the SBCH program. The results of the time study are incorporated into the CMS-approved SBCH program Cost Report. DSS has overall responsibility for the administration of the RMTS. For day-to-day administration of the RMTS, DSS has contracted with the University of Massachusetts Medical School (UMMS).

What is the RMTS?

The RMTS is an online system used to record the activities of staff identified for participation within the district. The RMTS is conducted for each quarter of the instructional school year:

Q#1 October 1st – December 31st

Q#2 January 1st – March 31st

Q#3 April 1st – June (the last day of school for the district)

Using school year calendar, workgroup, and participant information submitted through the UMMS system, RMTS moments are randomly selected prior to the start of each quarter. Direct service providers and Medicaid personnel time study participants will be chosen randomly from the universe of all direct providers included in the districts' cost pool. Moments are issued randomly for a moment in time (1 minute).

Direct Services Providers (includes qualified SBCH service providers and Medicaid Billing Personnel) will be separated into two pools:

- Nursing, Psychological and Medical Services Providers
- Therapy Services Providers

Administrative support staff will also be chosen randomly from the universe of all administrative staff included in the districts' lists and will be in their own independent cost pool. RMTS participants will answer the RMTS moment and denote what activity they were performing at their assigned moment (minute).

What are the School Districts' Responsibilities for the RMTS?

Each participating school district (LEA) is responsible for completing the following tasks to ensure successful execution of the time study process. DSS and UMMS will provide instructional materials, guidance, and deadlines on the completion of these very important tasks.

- Step 1: Designate a time study coordinator/contact person for all communication between UMMS, DSS, and the school district.
- Step 2: Prior to the start of the school year, provide group names to UMMS for the upcoming school year and enter district school year calendar information into the online UMMS RMTS system.
- Step 3: Upload to / Extract from the UMMS system a listing of available participants for the first quarter; update as necessary for each subsequent quarter.
- Step 4: Communicate any changes relating to participants (leave of absence, termination from district) using the Change of Status form. Change of participant status' are communicated directly to UMMS.
- Step 5: Monitor compliance within the district to ensure that the district is meeting a minimum of 85% compliance for each of the applicable cost pools. Districts which fail to maintain 85% compliance will receive warning notification letters and will be monitored in each of the subsequent quarters. Failure to maintain the compliance rate may result in the retention of district payments until the compliance rate is met.

How does the RMTS work?

User name and password information is distributed by UMMS via email to participants identified by the district prior to the start of the quarterly RMTS. Moments are issued electronically through the selected participants' email address.

Using the provided user name and password, selected participants log onto the UMMS system.

Participants must complete a brief 4 minute online training through the UMMS system one time every 365 days prior to completing their first moment request. Participants, once logged onto the system, answer 4 questions:

1. What type of activity were you doing?
2. What were you doing?
3. Who were you with?
4. Why were you performing this activity?

Participants may select answers to the questions from a list of predefined answers or, if none of the answers provided appropriately answer the questions, the participant has the opportunity to provide a written response.

Participants have 2 school days to answer moments from the date and time it is initially issued. For example, if the individual selected for the moment works Monday-Friday 7am-3:30p and they receive a moment on Tuesday 2/5/15 at 2:30p, they will have until Thursday, 2/7/15 at 2:30p to answer the moment.

Unanswered moments are considered expired and cannot be answered after their expiration date. Unanswered (expired) moments have a negative impact on the district's compliance rate.

Participants and Supervisors receive reminder notifications for unanswered moments as follows:

- At the moment (notification to the Participant)
- 4 hours after the moment is issued (notification to the Participant)
- 24 hours after the moment is issued (notification to the Participant)
- 28 hours after the moment is issued (notification to the Participant with a cc to the identified Supervisor)
- 12 hours prior to the expiration time (notification to the Participant with a cc to the identified Supervisor)

It is important to inform participants of the RMTS process, how it benefits your district financially, and the importance of participation with respect to compliance. Equally important is that staff maintains documentation to support the moments submitted through the RMTS process during the given quarter. Districts should devise a system of how documentation is collected and retained.

As stated above, the RMTS is entirely random in the selection of who receives a moment. There are no predefined expectations for districts and their participants when it comes to the frequency of moment requests.

Each quarter, the state or its designated contractor will randomly select a 5% sample of response for validation. The validation will consist of reviewing documentation from the selected participant (through their LEA) supporting the submission of the moment activity through the RMTS system.

Parental Consent

Effective March 18, 2013, the United States Department of Education promulgated the Individuals with Disabilities Education Act (IDEA) Part B final regulations that change the requirements in 34 C.F.R. § 300.154(d) related to parental consent to access public benefits or insurance (such as Medicaid). Previously, public agencies were required to obtain parental consent each time access to public benefits or insurance was sought.

The new rules ensure that parents of children with disabilities are informed of all of their legal protections when public agencies seek to access public benefits or insurance to pay for services. In addition, the new rules address the concerns expressed by State and local educational agencies that requiring parental consent each time access to public benefits or insurance is sought, in addition to the parental consent required by other federal statutes, imposes unnecessary costs and administrative burdens.

Specifically, these final regulations require that public agencies:

1. Obtain a one-time written consent from the parent, after providing the written notification described below, before accessing the child's or the parent's public benefits or insurance for the first time. This consent must specify the following:

- a. The personally identifiable information that may be disclosed (such as records or information about the services that may be provided to a particular child);
 - b. The purpose of the disclosure (such as billing for services);
 - c. The agency to which the disclosure may be made (such as Medicaid); and
 - d. That the parent understands and agrees that the public agency may access the child's or parent's public benefits or insurance to pay for services.
2. Provide written notification to the child's parent before accessing the child's or the parent's public benefits or insurance for the first time and prior to obtaining the one-time parental consent and annually thereafter. The written notification must explain all of the protections available to parents under Part B, as described in 34 C.F.R. § 300.154(d)(2)(v) to ensure that parents are fully informed of their rights before a public agency can access their or their child's public benefits or insurance to pay for services under the IDEA. The notice must be written in language understandable to the general public and in the native language of the parent or other mode of communication used by the parent, unless it is clearly not feasible to do so.

For additional information pertaining to Parental Consent, please visit the SBCH webpage at <http://www.ct.gov/dss/cwp/view.asp?a=2349&q=528684> .

Medicaid Billing

The Department of Administrative Services (DAS) functions as an authorized representative of the Local Educational Agency (LEA) subject to all the confidentiality requirements, regulations, and Statutes governing the State Department of Education (SDE) and the educational records of students including, but not limited to, the Family Educational Rights and Privacy Act (FERPA), 34 CFR Part 99; the confidentiality provisions of the Individuals with Disabilities Act (IDEA), 34 CFR Part 300; and Section 10-76 of the General Statutes of Connecticut, and Section 10-76d of the Regulation of Connecticut State Agencies.

DAS prepares and submits claims, by paper or electronic format, for all Medicaid eligible special education students for services provided accordingly with the student's Individualized Education Program (IEP) and covered under the Medicaid State Plan School Based Child Health Program. DAS receives and posts responses to the LEA submitted Medicaid claims, notifies submitting LEAs of identified errors, reviews, corrects and resubmits rejected claims for payment processing, develops and maintains the School Based Child Health Services billing and claiming system, and develops and maintains the electronic interface process with HP Enterprise Services, the DSS fiscal agent concerning claims submission and the Remittance Advice (RA).

All claims submitted to the Department for payment of SBCH health services must be substantiated by documentation in the eligible student's permanent service record. Final reimbursement is based on the certified reports that are submitted by LEAs based upon the methodology approved by CMS, which includes the scope of cost and methods of cost allocation that have been approved by CMS.

FFS Interim Rates are used to process claims for payment. Claims are paid at 25% of the FFP and are made through paper check mailed to the participating LEA. Payments are based upon claims which are received and processed during the specific claim period referenced on the payment spreadsheet provided to participating LEAs when payments are disbursed. Interim rates are provisional in nature, pending the completion of a cost reconciliation and cost settlement for the stated period.

School Based Child Health Covered Services, MSI Codes and Descriptions

Medicaid Service Information (MSI) Part 1 claim forms must be completed by the LEA for each Medicaid eligible student for services provided as recommended through the student's IEP. The MSI, Part 1 form must be completed at least on a monthly basis to record and log the amount of service time provided and should reflect the amount of service time written into the child's PPT for Medicaid eligible, SBCH covered health services (see matrix of SBCH covered health services). Forms may be obtained on the SBCH website at <http://www.ct.gov/dss/cwp/view.asp?a=2349&q=526930>. Click on the link labeled "Forms and Guides". A full copy of the Medicaid Billing Manual may also be found on the site.

For example (in district billing):

Discipline	Evaluations	Individual	Group	See Matrix
Assessment	21			
Audiology	21	22	23	
Counseling	81	82	83 (Psychologist, Social Worker, Counselor)	
Nursing	21	72	73	
Occupational Therapist	91	92	93	
Optometric Services	21	24		
Psychological Testing	71	82	83 (Psychiatrist, Psychologist)	
Physical Therapy	51	52	53	
Respiratory Care Services	21	42	44	
Speech and Language	01, 02, 03, 04	62	63	

For example (out of district billing):

Discipline	Evaluations	Individual	Group	See Matrix
Assessment	26			
Audiology	26	27	28	
Counseling	86	87	88 (Psychologist, Social Worker, Counselor)	
Nursing	26	77	78	
Occupational Therapist	96	97	98	
Optometric Services	26	29		
Psychological Testing	76	87	88 (Psychiatrist, Psychologist)	
Physical Therapy	56	57	58	
Respiratory Care Services	26	47	49	48
Speech and Language	06, 07, 08, 09	67	68	

SBCH Qualified Provider Titles and Qualifications

<u>Qualified Provider Title</u>	<u>Qualifications</u>
Advanced Practice Registered Nurse (APRN)	Means a person licensed under section 20-94a of the Connecticut General Statutes
Alcohol and Drug Counselor	Means a person licensed or certified pursuant to section 20-74s of the Connecticut General Statutes
Audiologist	Means a person licensed to practice audiology pursuant to section 20-395c of the Connecticut General Statutes
Audiology Assistant	Has the same meaning as provided in section 20-395a of the Connecticut General Statutes
Clinical Psychologist	Means a person licensed pursuant to section 20-188 to the Connecticut General Statutes
Licensed Clinical Social Worker (LCSW)	Means a person licensed pursuant to section 20-195n of the Connecticut General Statutes
Licensed Hearing Instrument Specialist	Has the same meaning as provided in section 20-396 of the Connecticut General Statutes
Licensed Practical Nurse (LPN)	Means a person licensed pursuant to section 20-96 of the Connecticut General Statutes
Licensed Professional Counselor	Means a person licensed pursuant to section 20-195dd of the Connecticut General Statutes
Licensed Speech and Language Pathologist	Has the same meaning as provided in section 20-408 and 20-410 of the Connecticut General Statutes
Marital and Family Therapist	Means a person licensed pursuant to section 20-195c of the Connecticut General Statutes

<u>Qualified Provider Title</u>	<u>Qualifications</u>
Naturopathic Physician	Means a person licensed pursuant to section 20-37 of the Connecticut General Statutes
Occupational Therapist	Means an individual licensed pursuant to section 20-74b or section 20-74c of the Connecticut General Statutes
Occupational Therapy Assistant	Has the same meaning as provided in section 20-74a of the Connecticut General Statutes
Optometrist	Means a person licensed pursuant to Chapter 380 of the Connecticut General Statutes to practice optometry as delineated in subsections (a) (1) and (2) of the section 20-127 of the Connecticut General Statutes
Physical Therapist	Means a person licensed pursuant to 20-70 or 20-71 of the Connecticut General Statutes
Physical Therapist Assistant	Has the same meaning as provided in section 20-66 of the Connecticut General Statutes
Physician	Means a person licensed pursuant to section 20-13 of the Connecticut General Statutes
Physician Assistant	Means a person licensed pursuant to section 20-12b of the Connecticut General Statutes
Respiratory Care Practitioner	Has the same meaning as provided in 20-162n of the Connecticut General Statutes
Registered Nurse (RN)	Means a person licensed to practice nursing pursuant to subsection (a) of section 20-87a of the Connecticut General Statutes
School Counselor (includes previously Certified Guidance Counselor)	Means a person certified by the State Department of Education pursuant to 10-145d-556 to 10-145d-558, inclusive, of the Regulations of Connecticut State Agencies

<u>Qualified Provider Title</u>	<u>Qualifications</u>
School Marriage and Family Therapist	Means a person certified by the State Department of Education pursuant to 10-145d-556b to 10-145d-566f, inclusive, of the Regulations of Connecticut State Agencies
School Nurse	Means a person certified by the State Department of Education pursuant to sections 10-145d-548 to 10-145d-550, inclusive, of the Regulations of Connecticut State Agencies
School Psychologist	Means a person certified by the State Department of Education pursuant to sections 10-145d-560 to 10-145d-562, inclusive, of the Regulations of Connecticut State Agencies
School Social Worker	Means a person certified by the State Department of Education pursuant to section 10-145d-564 to 10-145d-566, inclusive, of the Regulations of Connecticut State Agencies
Speech and Language Pathologist Assistant	Means a person providing assistance to a speech and language pathologist pursuant to subsection (5) of section 20-413 of the Connecticut General Statutes

MATRIX – School Based Child Health Covered Services, MSI Codes and Descriptions

ASSESSMENT

<u>MSI Code</u> (In-district)	<u>MSI Code</u> (Out of district)	<u>Unit of Service/Max Units</u>	<u>CPT Code</u>	<u>Description</u>	<u>Practitioner</u>	<u>State Plan Description</u>
15	20	15 min / 8 units max	97755	Assistive Technology Assessment (to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility (direct 1:1 contact by provider, with written report	Audiologist, Audiologist Assistant, Chiropractor, Counselor, Hearing Instrument Specialist, Naturopath, Nurse LPN, Nurse Practitioner (APRN), Nurse (RN), Occupational Therapist, Occupational Therapy Assistant, Optometrist, Physical Therapist, Physical Therapy Assistant, Physician, Podiatrist, Psychiatrist, Psychologist, Respiratory Therapist, Social Worker, Speech-Language Pathology Assistant	“Assessment” means an evaluation conducted to determine a child’s health related needs for purposes of the IEP and shall be covered, as necessary, to assess or reassess the need for medical services in a child’s treatment plan. Assessment services include the identification and assessment of health-related needs for medical services for the purpose of determining educational recommendations. Payment for the assessment costs is available under Medicaid once a child’s IEP has been approved.
21	26			Unlisted evaluation and management services (per 15 minutes, up to a maximum of six services per member per date of service)		

AUDIOLOGY

<u>MSI Code</u> (In-district)	<u>MSI Code</u> (Out of district)	<u>Unit of Service</u>	<u>Description</u>	<u>Practitioner</u>	<u>State Plan Description</u>
22	27	15 min	Hearing Screening	Audiologist, Audiologist's Assistant under the direction of the Audiologist	<p>Audiology services include those services as defined in Subsection (3) of Section 20-408 of the CGS. Audiology services are provided by providers who meet the qualifications in accordance with 42 CFR 440.110(c)(3) and acting within his or her scope of practice under Connecticut State Law who is licensed to practice audiology pursuant to section 20-395 (a), (c) of the Connecticut General Statutes. Audiology services means services that include the following:</p> <ul style="list-style-type: none"> • Identification of children with hearing loss; • Determination of the range, nature and degree of hearing loss, including referral for medical or other professional attention for the treatment of hearing; • Provision of treatment activities, such as language habilitation, auditory training, speech reading (lip reading), hearing evaluation and speech conservation; • Creation and administration of programs for the prevention of hearing loss; • Determination of the child's need for individual or group amplification, selecting and fitting an appropriate aid and evaluating the effectiveness of amplification.
23	28	15 min	Hearing Service, miscellaneous	Audiologist, Audiologist's Assistant under the direction of the Audiologist Hearing Instrument Specialist	

BEHAVIORAL HEALTH SERVICES

<u>MSI Code (In-district)</u>	<u>MSI Code (Out of district)</u>	<u>Unit of Service/Max Units</u>	<u>CPT Code</u>	<u>Description</u>	<u>Practitioner</u>	<u>State Plan Description</u>
81	86	Per hour	90801	Psychiatric diagnostic interview examination	Psychiatrist, Psychologist, Social Worker, Counselor	<p>Behavioral health services means diagnostic and treatment services involving mental, emotional, or behavioral problems; disturbances or dysfunctions; or the diagnosis and treatment of substance abuse. Services include those within the scope of practice set forth in Subsections (a) and (b) of Section 20-195, Subsection (a) of Section 20-195a, Subsection (a) of Section 20-195m, and Subsection (b) of Section 195-a of the CGS. Behavioral health services must be provided by a qualified provider who meets the requirements of 42 CFR Section 440.60 or 42 CFR Section 440.50(a). Behavioral Health services include, but are not limited to:</p> <ul style="list-style-type: none"> • Mental Health evaluations; • Psychological testing including, but not limited to: <ul style="list-style-type: none"> a. Administration of psychological tests and other assessment procedures; b. Interpretation of assessment results; c. Acquisition, integration, and interpretation of information about child behavior and conditions related to learning; and d. Planning and management of a program of psychological services including psychological counseling for children and parents. • Counseling services such as individual, group or marital and family counseling, or psychotherapy for the treatment of mental, emotional, behavioral or substance abuse condition to alleviate the condition and encourage growth and development.
71	76	Per hour / 8 units max	96101	Psychological testing (includes psychodiagnostic assessment of emotionally, intellectual abilities, personality and psychopathology, per hour of the psychologist's or physician's time, both face-to-face time with the administering tests to the patient and time spent interpreting test results and preparing the report (may bill multiple units)	Psychiatrist, Psychologist	
82	87	30 min / 8 units max	90832	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, face-to-face with the patient (may bill multiple units)	Psychologist, Social Worker, Counselor	
83	88	15 min / 4 units max	90853	Group Psychotherapy (other than of a multiple-family group), may bill multiple units	Psychologist, Social Worker, Counselor	
84	89	15 min	90847	Family psychotherapy (conjoint psychotherapy) with patient present, may bill multiple units	Psychologist, Social Worker, Counselor	

CLINICAL DIAGNOSTIC LABORATORY SERVICES

<u>MSI Code</u> (In-district)	<u>MSI Code</u> (Out of district)	<u>Unit of Service</u>	<u>Description</u>	<u>Practitioner</u>	<u>State Plan Description</u>
14	19		Unlisted chemistry procedure	N/A	<p>Clinical diagnostic laboratory services include those services recommended by the PPT such as simple diagnostic tests and procedures performed in the school. Clinical diagnostic laboratory services are provided by providers who meet the qualifications in accordance with 42 CFR 440.30 and 42 CFR 440.130 and acting within his or her scope of practice under Connecticut State Law. These service include, but are not limited to:</p> <ul style="list-style-type: none"> • Blood sugar by a finger stick; • Urine dipstick, and • Hematocrit

MEDICAL SERVICES

<u>MSI Code</u> (In-district)	<u>MSI Code</u> (Out of district)	<u>Unit of Service</u>	<u>Description</u>	<u>Practitioner</u>	<u>State Plan Description</u>
12	17	Per encounter	Screening to determine the appropriateness of consideration of an individual for participation in a specified program, project or treatment protocol, per encounter	Physician, Chiropractor, Podiatrist, Naturopath, Optometrist	<p>Medical services means medical diagnostic and evaluative services recommended by the PPT to determine the child's medically related disability as approved by the licensed practitioner of the healing arts as defined in Section 20-1 of the CGS and provided by the qualified SBCH service provider. These services include, but are not limited to:</p> <ul style="list-style-type: none"> • Medical evaluations used to identify a child's health related needs as a part of the IEP process; and • Medically necessary EPSDT services including health care services, diagnostic services, treatments and other measures to correct and ameliorate physical defects, mental illnesses and other disabilities.

NURSING SERVICES

<u>MSI Code</u> (In-district)	<u>MSI Code</u> (Out of district)	<u>Unit of Service /</u> <u>Max</u> <u>Units</u>	<u>CPT Code</u>	<u>Description</u>	<u>Practitioner</u>	<u>State Plan Description</u>
72	77	15 min / 32 units	T1002	Services up to 15 minutes (may bill multiple units)	Nurse (RN or APRN)	<p>Nursing services include those services within the scope of practice set forth in Subsections (a), (b), and (c) of Section 20-87a of the CGS. Nursing services include, but are not limited to:</p> <ul style="list-style-type: none"> • Assessment and development of individualized health care plans;; • Medical treatments and procedures including, but not limited to, suctioning, tracheotomy care, catheterization, toileting, ostomy management and care; • Administration or monitoring of medication needed by a student during school hours; • Consultation with licensed physicians, parents and staff regarding the effect of the medication; • Monitoring of health status, for example, monitoring of shunt functioning or respiratory status; and • Individual health counseling and instruction and emergency interventions.
73	78	15 min / 32 units	T1003	LPN/LVN Services, up to 15 minutes (may bill multiple units)	Nurse (LPN)	

OPTOMETRIC SERVICES

<u>MSI Code</u> (In-district)	<u>MSI Code</u> (Out of district)	<u>Unit of Service</u>	<u>Description</u>	<u>Practitioner</u>	<u>State Plan Description</u>
24	29	15 min	Vision service, miscellaneous	Optometrist, Physician, Nurse Practitioner (APRN)	<p>Optometric services include those services as defined in Section 20-127 of the Connecticut General Statutes. Optometric services are provided by or under the direction of providers who meet the qualifications in accordance with 42 CFR 440.50(a), 440.166(a) and acting within his or her scope of practice under Connecticut State Law. Optometric services include, but are not limited to:</p> <ul style="list-style-type: none"> • The assessment for visual acuity, color blindness, near vision and strabismus; and • The diagnosis of abnormalities related to the eye and optic nerve.

OCCUPATIONAL THERAPY

<u>MSI Code</u> (In-district)	<u>MSI Code</u> (Out of district)	<u>Unit of Service/Max Units</u>	<u>CPT Code</u>	<u>Description</u>	<u>Practitioner</u>	<u>State Plan Description</u>
91	96	15 min 2 hours max (8 units)		Occupational Therapy Evaluation	Occupational Therapist	<p>Occupational therapy services include those services as defined in Subsection (1) of Section 20-74a of the CGS. Occupational therapy services are provided by or under the direction of providers who meet the qualifications in accordance with 42 CFR 440.110(b) and acting within his or her scope of practice under Connecticut State Law. Occupational therapy services include, but are not limited to:</p> <ul style="list-style-type: none"> • Identification of children with occupational therapy needs; • Evaluation for the purpose of determining the nature, extent and degree of the need for occupational therapy services; • Improving, developing or restoring functions impaired or lost through illness, injury, or deprivation; • Preventing through early intervention, initial or further impairment or loss of function; and • Planning and utilization of a program of activities to develop or maintain adaptive skills designed to achieve maximum physical and mental functioning of the student in daily life tasks.
92	97	15 min / 8 units max	97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercised to develop strength and endurance, range of motion and flexibility (may bill multiple units)	Occupational Therapist, Occupational Therapy Assistant	
93	98	15 min / 8 units max	97150	Therapeutic procedure(s) group (two or more individuals) per 15 minutes, may bill multiple units	Occupational Therapist, Occupational Therapy Assistant	

PHYSICAL THERAPY

<u>MSI Code</u> (In-district)	<u>MSI Code</u> (Out of district)	<u>Unit of Service/Max Units</u>	<u>CPT Code</u>	<u>Description</u>	<u>Practitioner</u>	<u>State Plan Description</u>
51	56	15 min 2 hour max (8 units max)		Physical Therapy Evaluation	Physical Therapist	<p>Physical Therapy services include those services as defined in subsection (2) of Section 20-66 of the CGS. Physical therapy services are provided by or under the direction of providers who meet the qualifications in accordance with 42 CFR 440.110(a) and acting within his or her scope of practice under Connecticut State Law. Physical therapy services include, but are not limited to:</p> <ul style="list-style-type: none"> • Identification of children with physical therapy needs; • Evaluation for the purpose of determining the nature, extent and degree of the need for physical therapy services; • The provision of physical therapy services for the purpose of preventing or alleviating movement dysfunction and related functional problems; • Obtaining, interpreting, and integrating information appropriate to program planning; • Diagnosis and treatment of physical disability, injury or disease using physical and mechanical means, including, but not limited to heat, cold, light, air, water, sound, electricity, massage, mobilization, and therapeutic exercise with or without assistive devices; and • The performance and interpretation of tests and measurements to assist pathopsychological, pathomechanical and developmental deficits of human systems to determine treatment and assist in diagnosis and prognosis.
52	57	15 min / 8 units max	97110	Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercised to develop strength and endurance, range of motion and flexibility (may bill multiple units)	Physical Therapist, Physical Therapy Assistant	
53	58	15 min / 8 units max	97150	Therapeutic procedure(s) group (two or more individuals) per 15 minutes, may bill multiple units	Physical Therapist, Physical Therapy Assistant	

RESPIRATORY CARE SERVICES

<u>MSI Code</u> (In-district)	<u>MSI Code</u> (Out of district)	<u>Unit of Service</u>	<u>Description</u>	<u>Practitioner</u>	<u>State Plan Description</u>
42	47	15 min	Therapeutic procedures to increase strength or endurance of respiratory muscles, face-to-face, one-to-one, each 15 minutes (includes monitoring)	Respiratory Therapist	<p>Respiratory care services include those services as defined in Subsection (2) of Section 20-162n of the CGS. Respiratory care services are provided by or under the direction of providers who meet the qualifications in accordance with 42 CFR 440.130 and acting within his or her scope of practice under Connecticut State Law.</p>
43	48	15 min	Therapeutic procedures to improve function, other than described by CG037, face-to-face, one-to-one, each 15 minutes (includes monitoring)	Respiratory Therapist	
44	49	15 min	Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring)	Respiratory Therapist	

SPEECH AND LANGUAGE PATHOLOGY SERVICES

<u>MSI Code (In-district)</u>	<u>MSI Code (Out of district)</u>	<u>Unit of Service/Max Units</u>	<u>CPT Code</u>	<u>Description</u>	<u>Practitioner</u>	<u>State Plan Description</u>
01	06	Per Evaluation	92521	Evaluation of speech fluency (e.g., Stuttering, cluttering)	Speech-Language Therapist	<p>Speech and language pathology services have the same meaning as provided in section 20-408 of the CGS. Speech/Language services are provided by or under the direction of providers who meet the qualifications in accordance with 42 CFR 440.110(c) and acting within his or her scope of practice under Connecticut State Law. Speech and language pathology services include but are not limited to:</p> <ul style="list-style-type: none"> • The identification of children with speech and language impairments; • The diagnosis and appraisal of specific speech and language impairments; • Referrals for medical or other professional attention necessary for the treatment of speech or language impairments; • Provision of speech or language services for the treatment or prevention of communicated impairments; • Evaluation of and application of principles, methods, and procedures of measurement, prediction, diagnosis, testing, counseling, consultation, rehabilitation, and instruction related to the development of speech, voice or language; and • Preventing, ameliorating or modifying speech disorder conditions in children or groups of children.
02	07	Per Evaluation; Cannot be billed with MSI Code 03	92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)	Speech-Language Therapist	
03	08	Per Evaluation; Cannot be billed together with MSI Code 02	92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)	Speech-Language Therapist	
04	09	Per Evaluation	92524	Behavioral and qualitative analysis of voice resonance	Speech-Language Therapist	
62	67	15 min, 4 hour max (8 units max)	92507	Treatment of speech, language, voice, communication, and/or auditory disorder (per 15 minutes, may bill multiple units)	Speech-Language Therapist, Speech-Language Pathology Assistant, or Audiologist's Assistant	
63	68	15 min / 8 units max	92508	Treatment of speech, language, voice, communication and/or auditory processing disorder; group, two or more individuals (per 15 minutes, may bill multiple units)	Speech-Language Therapist, Speech-Language Pathology Assistant, or Audiologist's Assistant	

***In the case that an Evaluation for a child is conducted across a time-period involving more than one day (for example, 15 minutes carried out on Day 1, 15 minutes carried out on Day 2, etc.), the practitioner should not submit a bill for that given Evaluation until the date of completion of that Evaluation. Each of the new services codes may thus be billed (in accordance with the Special Rules noted) once per Evaluation per child, upon the date of completion of that Evaluation. Multiple bills should not be submitted for the same Evaluation for the same child that is conducted over the course of more than one day.

SBCH FFS Interim Rates
Effective July 1, 2013 and forward
Speech Codes updated January 1, 2014

Service Definitions	Procedure Code	MSI Code - In District	MSI Code - Out of District	Interim FFS for Dates of Service 6/30/13 and prior	Interim FFS for Dates of Service 7/1/13 and forward	Session Time/Units	Units per Procedure Code	Procedure Code Description
10-Counseling; 40-Counseling	96101	71 (per hour)	76 (per hour)	\$74.40	\$186.00	per Hour	8 x \$186.00 per IC	Psychological Testing (per hour) use one unit increments
	90791/90801	81 (per hour)	86 (per hour)	\$74.40	\$186.00	per Hour	8 x \$186.00 per IC	Psychiatric diagnostic interview examination (per hour) use one unit increments
	90804/90832	82 (per 30 min)	87 (per 30 min)	\$27.00	\$67.50	per 30 minutes	8 x \$67.50 per IC	Individual psychotherapy (20-30 minutes) use one unit increments
	90853	83	88	\$6.75	\$16.88	per 15 minutes	4 x \$16.88 per IC	Group Psychotherapy- 15 minutes
	90847	84	89	\$13.50	\$33.75	per 15 minutes	8 x \$33.75 per IC	Family Psychotherapy - 15 minutes
11-Speech & Language Therapy; 41-Speech & Language Therapy	92506*	61 (per hour)	66 (per hour)	\$54.00	\$135.00	per Hour	8 x \$135.00 per IC	Evaluation of speech, language, voice (per hour) use one unit increments
	92507	62	67	\$13.50	\$33.75	per 15 minutes	8 x \$33.75 per IC	Treatment of speech, language, voice -15 minutes
	92508	63	68	\$6.75	\$16.88	per 15 minutes	8 x \$16.88 per IC	Treatment of speech, language, voice group -15 minutes
	92521	01	06	n/a	\$45.00	per session	1 per IC	Evaluation of speech fluency (e.g., stuttering, cluttering)
	92522	02	07	n/a	\$45.00	per session	1; Cannot be billed together with 92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)
	92523	03	08	n/a	\$90.00	per session	1; Cannot be billed together with 92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)
	92524	04	09	n/a	\$45.00	per session	1 per IC	Behavioral and qualitative analysis of voice and resonance
08-Occupational Therapy; 38-Occupational Therapy	97003	91 (per visit=hour)	96 (per visit=hour)	\$40.80	\$102.00	per Hour	8 x \$102.00 per IC	OT evaluation (per visit) use one unit increments
	97110	92	97	\$10.20	\$25.50	per 15 minutes	8 x \$25.50 per IC	OT Therapeutic procedure - 15 minutes
	97150	93	98	\$5.10	\$12.75	per 15 minutes	8 x \$12.75 per IC	OT Therapeutic procedure group - 15 minutes
09-Physical Therapy; 39-Physical Therapy	97001	51	56	\$40.80	\$102.00	per Hour	8 x \$102.00 per IC	PT Evaluation (per visit) use one unit increments
	97110	52	57	\$10.20	\$25.50	per 15 minutes	8 x \$25.50 per IC	PT Therapeutic procedure - 15 minutes
	97150	53	58	\$5.10	\$12.75	per 15 minutes	8 x \$12.75 per IC	PT Therapeutic procedure group - 15 minutes
	97755	15	20	\$13.50	\$33.75	per 15 minutes	8 x \$33.75 per IC	Assistive Technology Assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility); direct one-on-one contact by provider, with written report, each 15 minutes
	99499	21	26	\$13.50	\$33.75	per 15 minutes	6 x \$33.75 per IC	Assessments, Misc; Unlisted Evaluation and Management services (per 15 minutes, up to maximum of six services per member per date of service)

Fee for Service Interim Rates

SBCH FFS Interim Rates
Effective July 1, 2013 and forward
Speech Codes updated January 1, 2014

Service Definitions	Procedure Code	MSI Code - In District	MSI Code - Out of District	Interim FFS for Dates of Service 6/30/13 and prior	Interim FFS for Dates of Service 7/1/13 and forward	Session Time/Units	Units per Procedure Code	Procedure Code Description
xx-Respiratory Therapy	G0237	42	47	\$8.60	\$21.50	per 15 minutes	8 x \$21.50 per IC	Therapeutic procedures to increase strength and endurance of respiratory muscles (15 minutes)
	G0238	43	48	\$8.60	\$21.50	per 15 minutes	8 x \$21.50 per IC	Therapeutic procedures to improve respiratory function, other than described in G0237 (15 minutes)
	G0239	44	49	\$8.60	\$21.50	per 15 minutes	8 x \$21.50 per IC	Therapeutic procedures to improve respiratory function, group - 15 minutes
07- Nursing Services; 37-Nursing Services	T1002	72	77	\$12.90	\$32.25	per 15 minutes	32 x \$32.25 per IC	RN, APRN services - up to 15 minutes
	T1003	73	78	\$12.90	\$32.25	per 15 minutes	32 x \$32.25 per IC	LPN/LVN services - up to 15 minutes
06-Medical Services; 36-Medical Services	T1023	12 (per visit=2 units)	17 (per visit=2 units)	\$33.00	\$82.50	per session	1	Service by a medical doctor (per visit) use one unit increments
	V2799	24	29	\$18.60	\$46.50	per 15 minutes	8 x \$46.50 per IC	Vision service, miscellaneous - 15 minutes
03-Audiology; 33-Audiology	V5008	22	27	\$13.50	\$33.75	per 15 minutes	8 x \$33.75 per IC	Hearing Screening - 15 minutes
	V5299	23	28	\$13.50	\$33.75	per 15 minutes	4 x \$33.75 per IC	Hearing Services - 15 minutes

****Effective 1/1/14, MSI Code 61 (CPT Code 92506) has been deleted and replaced with 4 new, specific evaluation codes (92521, 92522, 92523, 92524)**

SBCH Cost Report and Settlement Process

The SBCH Time Study, Cost Report, and Settlement process are all related to one another. The Department provides participating SBCH districts with the necessary electronic form (excel spreadsheet) and instruction guide to prepare the annual cost report. Cost Reports are for all services delivered during the previous state fiscal year covering July 1st through June 30th. Cost reports are due to the State no later than June 30th of the year following the close of the year during which the costs included in the Cost Report were accrued. Submitted cost reports are subject to desk review by the Department, whereas DSS staff reviews costs and staff reported to the Time Study participant pool to ensure acceptable SBCH cost items have been included. As part of the review process, DSS may request additional information (RAI) from the district to complete the desk review process.

To determine the Medicaid allowable costs of providing SBCH service, the following is considered, calculated and applied:

- a. Direct costs of providing SBCH services include payroll costs and other costs that can be directly charged to SBCH services including costs that are integral to SBCH services. Direct costs shall not include room and board. Other direct costs include costs directly attributable to activities performed by the personnel who are approved to deliver SBCH services, including but not limited to travel, purchased services, materials and supplies. These direct costs are accumulated on the annual SBCH Cost Report, approved by CMS.
- b. Direct costs for SBCH services from item a above are reduced by any federal payments for those costs, resulting in adjusted direct costs for SBCH services.
- c. Adjusted direct costs from item b above are then allocated to identify Medicaid-reimbursable costs for SBCH services according to the time study results that are identified according to the process described in the SBCH Time Study User Guide, approved by CMS.
- d. Indirect costs are calculated using the unrestricted indirect cost rate set by the Connecticut State Department of Education as the cognizant agency. Indirect costs are equal to adjusted direct costs (b) multiplied by the unrestricted indirect cost rate. These indirect costs are then added to the adjusted direct costs (b) to determine the total SBCH costs.
- e. Medicaid allowable costs are identified applying the Medicaid penetration rate to the total direct costs (d). The Medicaid penetration rate is the average of the number of Medicaid enrolled students with an IEP as of the 5th day after the start of the quarter divided by the average of the total number of students with an IEP on the same day.

Each district's specific Medicaid penetration rate is applied to their Medicaid-reimbursable direct costs to determine their Medicaid-allowable direct costs for the SBCH program. Final district SBCH direct Medicaid-allowable costs are compared to the Interim claims submitted and paid throughout the school year and the variance (Costs-Claims) amount, also known as the settlement amount, is either paid to the district at 25% (if costs exceed claims) or recouped from the district at 25% (if costs do not exceed claims)

Administrative costs are reported on the Admin Register Sheet and the Direct Service Provider Register sheets by each participating district. Administrative costs are used to determine the district's Medicaid-reimbursable admin costs for SBCH using the state-wide time study results for admin providers and direct service providers. Each time study pool has administrative activities that result in the Medicaid administrative percentage. The Time Study percentages are applied to Worksheet #2a Administrative staff. Also included in the determination of administrative costs is the depreciation for equipment and building improvements, with no time study effort application.

Each district's Medicaid penetration rate is then applied to their Medicaid-reimbursable administrative costs to determine their Medicaid-allowable admin costs for the SBCH program. Since the administrative claim is done at the final settlement, the result is the payment of the administrative claim at the 25% rate, similar to the payment percentage on the direct costs. Cost Reports will be reconciled within 24 months of the reporting period contained in the SBCH service providers' submitted cost report.

Each SBCH services LEA certifies on an annual basis through its completed SBCH Cost Report its total actual, incurred Medicaid allowable costs, including the federal share and the nonfederal share. These costs do not include any indirect costs that are not included in the unrestricted cost rates approved by the Connecticut State Department of Education as the cognizant agency.

Funds Usage, Documentation & Records Retention Requirements

Funds Usage – As stated in Connecticut General Statute Conn. Gen. Stat. § 10-76d (2013)

(a)(6) Payments received pursuant to this section shall be paid to the local or regional board of education which has incurred such costs in addition to the funds appropriated by the town to such board for the current fiscal year.

A permanent service record documenting each SBCH service provided to each Medicaid eligible child shall be maintained by the LEA at which the child is enrolled at the time of service. The permanent service record may be in paper or electronic format, shall provide an audit trail, and shall include, but is not limited to:

- a. The written evaluation and the results of any diagnostic tests;
- b. The child's diagnosis, in a manner acceptable to the department;
- c. The IEP signed in accordance with section 10-76d (b) (9) of the Connecticut General Statutes; and
- d. Progress notes signed by a licensed or certified allied health professional which performed or supervised the services within the scope of his or her practice under state law.

For each date of service, the qualified health care provider shall keep a service record within the child's record containing all of the following:

- a. The date of service;
- b. The type of service;
- c. The units of service;
- d. A brief description of the service provided;
- e. Whether the service was performed in a group or individual setting; and

f. The signature of the qualified health care provider performing the service

The LEA shall maintain a current record of the applicable license(s) or certification(s) of practice of all licensed or certified persons performing SBCH services.

The LEA shall maintain all supporting records of costs reported for SBCH services. All records shall be maintained for a period of at least 6 years.

Audit & Compliance Review

All supporting accounting and business records, statistical data, the child's permanent service record and all other records relating to the provision of SBCH covered services paid for by the Department shall be subject to audit or compliance review by authorized personnel. If an audit discloses discrepancies in the accuracy or allow ability of actual direct or indirect costs or statistical data as submitted for each state fiscal year by the State Department of Education and its LEAs, the department's rate for said period shall be subject to adjustment. All documentation shall be made available to authorized personnel upon request in accordance with 42 CFR, Part 431. The SDE shall take full responsibility for any Medicaid claims disallowed due to inadequate documentation by any LEA or failure to comply with requirements set forth in statute or regulation.